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By: _____
Peter J. Heck (PJH-6760)

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ZEV AND LINDA WACHTEL, individually and on behalf of their minor son, TORY WACHTEL, and on behalf of all others similarly situated,	**:UNITED STATES DISTRICT COURT :DISTRICT OF NEW JERSEY :Civil Action No. 2:01-cv-4183 (FSH)(SRC)**
Plaintiffs,	
vs.	
GUARDIAN LIFE INSURANCE COMPANY OF AMERICA, PHYSICIANS HEALTH SERVICES, INC. and PHYSICIANS HEALTH SERVICES OF NEW JERSEY, INC.,	
Defendants.	

CIVIL ACTION - CERTIFICATION OF COUNSEL

I, **PETER J. HECK, ESQ.**, of full age, being duly sworn according to law and upon my oath, depose and say:

1. I am an attorney at law of the State of New Jersey and am associated with the law firm of Del Mauro, DiGiaimo & Knepper, P.C., attorneys for defendant, Guardian Life Insurance Company of America ("Guardian Life"), in the above-captioned matter. As such, I am fully familiar with the facts and circumstances contained herein and am authorized to submit this

certification in support of Guardian Life's motion to dismiss plaintiffs' first amended complaint pursuant to FED. R. CIV. P. 12(b)(6).

2. In support of the motion to dismiss, Guardian Life relies upon all pleadings and proceedings in this case to date, notice of motion, proposed form of order and legal memorandum, as well as all plan documents referenced in the complaint and previously produced by counsel for plaintiffs. Annexed hereto as Exhibit A are true and accurate copies of those plan documents produced to this office by counsel for plaintiffs.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

DEL MAURO, DIGIAIMO & KNEPPER, P.C.
Attorneys for Defendant,
Guardian Life Insurance Company of America

Date: February 1, 2002

By: _____
Peter J. Heck (PJH-6760)

Guardian\Wachtel\Certification of Counsel
4044.104

phs health plans℠ You Matter.™

One Far Mill Crossing ■ P.O. Box 904 ■ Shelton, CT 06484-0944 ■ www.phshealthplans.com

Welcome to Healthcare Solutions

Dear Member,

We appreciate the confidence you've expressed in us by choosing Healthcare Solutions, from Guardian and PHS Health Plans. In the coming months, we'll work to provide you with the best service possible.

Your member ID card(s) were already mailed under separate cover. Please present your card each time you seek medical treatment and, if you have a Healthcare Solutions pharmacy plan, when you fill a covered prescription.

This Member Guide contains important information about using your health benefits. Inside you will find:

- Your Subscriber Agreement or Evidence of Coverage*, and any applicable amendments* and riders*;
  (Attention New York point-of-service members: Your Summary Plan Document* will be issued by Guardian, and will be mailed under separate cover in the next few weeks.)
- A member handbook, which explains how to use the plan, plus information on how to access the PHS Healthy Extras program; and
- Information about accessing your prescription drug coverage, if applicable.

Please review this guide and then put it in a convenient place for future reference.

There may also be a survey enclosed. The survey is placed in randomly selected Member Guides to help us determine whether the information provided is useful and understandable to our members. If a survey is enclosed at the front of your booklet, please take a couple of minutes to complete it and then return it to us. Your anonymous answers will be tabulated with other responses, analyzed and used to enhance the member materials we create in the future.

If you have any questions, please call our toll-free customer service number on your member ID card. Service representatives are available Monday through Friday, 8 a.m. to 6 p.m. You can also e-mail your questions to ***member@phshealthplans.com.***

To find out if a physician or provider participates with PHS Health Plans, you can use our searchable physician/provider directory on our web site (***www.phshealthplans.com***). You can also call the Interactive Provider Directory line (800-686-9847) to have a list of the 100 closest providers faxed or mailed to you.

Again, thank you for choosing Healthcare Solutions.

Respectfully,

Kate Longworth-Gentry
Senior Vice President, Customer and Provider Call Unit

* subject to regulatory approval

PHS Health Plans is Physicians Health Services, Inc. Services are underwritten as follows: CT: HMO and POS by Physicians Health Services of Connecticut, Inc.; NJ: HMO and POS by Physicians Health Services of New Jersey, Inc.; NY: HMO and POS by Physicians Health Services of New York, Inc. Out-of-network services may be underwritten by Physicians Health Services Insurance of New York, Inc., or for the Healthcare Solutions POS, by The Guardian Life Insurance Company of America, New York, NY (GP-1-JV-HCS-NY-1). Physicians Health Services, Inc. is a wholly owned subsidiary of Foundation Health Systems, Inc., which is traded on the NYSE under the ticker symbol FHS.

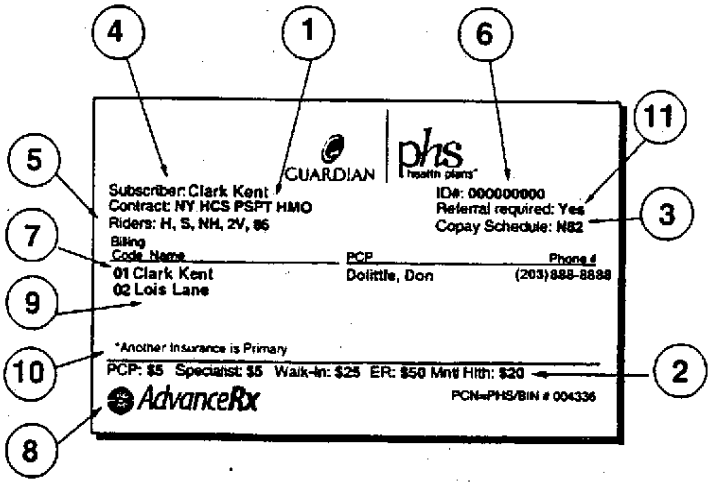
Understanding Your ID Card

This is a sample of the information that appears on a typical new PHS Health Plans ID card. Certain plans feature additional types of co-payments.

A new ID card will be automatically sent to you when:

- A new member enrolls on your policy
- A member on your policy changes his or her name
- A dependent is added or deleted from your policy

1. **Contract:** This is the name of your PHS Health Plans contract and indicates the set of benefits for which you are eligible. Depending on your benefit contract, this description may vary.
2. **Co-payment:** The dollar amount indicates the co-payment that will be required at the time of service from a participating physician and provider.
3. **Copay Schedule:** This code assists participating physicians and providers in identifying the co-payments that you must pay when receiving services.
4. **Subscriber:** This is the name of the person who is the policy holder.
5. **Riders:** The codes refer to any additional coverage provided by the member's plan.
6. **ID #:** This is the subscriber's Social Security number. This number, along with the two-digit code that appears next to your name, is used to identify you as an eligible member.
7. **Billing Code:** This identifies the specific PHS Health Plans member.
8. **Advance Rx:** If you have prescription coverage with PHS Health Plans, this vendor is responsible for paying your prescription claims. (You will receive a new ID card if the pharmacy vendor changes.)
9. **Name:** Identifies the subscriber and eligible members.
10. **Footnote:** An asterisk preceding a member's first name indicates that another health plan is the primary insurer for that individual.
11. **Referral Required: No:** Your plan does not require a referral from your primary care physician (PCP) to see a participating specialist.



The Stage 1 appeal is an internal review of the initial decision(s) to deny a medical procedure, supply and/or admission. You or a provider will have up to 60 days to file a Stage 1 appeal. The 60-day period begins on the date of receipt of the PHS Health Plans initial notice of adverse determination. Stage 1 appeals can be initiated by telephone or in writing. If the case involves urgent or emergency care, or the member is confined as an inpatient, a decision on the appeal will not take longer than 72 hours. All other cases will be decided within five business days. The appeal is informal and allows you or your representative to discuss your case with the Medical Director who made the initial decision.

When a Stage 1 appeal is completed, you or your provider designee will be informed of the decision. If there is an adverse determination, PHS Health Plans will provide you and/or your provider designee with written notification. The notification will include the basis for the decision and an explanation of how to proceed to a Stage 2 appeal.

The Stage 2 appeal is a formal review of all medical records and other pertinent information by a clinical appeal panel of physicians and/or health care professionals who were not involved in the Stage 1 appeal. A Stage 2 appeal must be initiated 60 days from the date that you and/or your provider received notification of its Stage 1 appeal decision. Stage 2 appeals may also be requested either by telephone or in writing. We will send you our acknowledgement of your request within 10 days of receipt of your letter. A clinical peer who is trained or practices in the specialty of the case at issue will be available to the panel. Upon request, you or your provider may appear before the panel. You or your provider may also request that the clinical peer participate in the panel's review of the case. If the case involves urgent or emergency care, the panel will conclude its Stage 2 appeal no later than 72 hours after receipt by PHS Health Plans of all pertinent information. All other cases will be concluded within 20 business days. When there is a reasonable cause for a delay that is beyond the control of PHS Health Plans, PHS may extend the review for up to an additional 20 business days where it provides a written progress report and explanation for the delay to the satisfaction of the Department. Notice of the delay and need for additional time must be made to you and/or your provider during the original 20-day period. If the panel decides to uphold the adverse determination, the written notice will include the basis for its decision. A notice upholding the adverse determination will also include specific instructions on how you or your provider may initiate a Stage 3 external appeal and any necessary forms.

A Stage 3 external appeal may be requested if you, or your provider acting on your behalf, disagree with the PHS Health Plans Stage 2 appeal determination. The Stage 3 appeal is a review of all pertinent information by an external review organization designated by the New Jersey Department of Health and Senior Services. A request for an external appeal must be filed with the Department within 60 days from the receipt of the written determination of the Stage 2 internal appeal panel. External appeals are subject to a filing fee of $25 unless financial hardship is demonstrated through evidence of eligibility for the Pharmaceutical Assistance to the Aged and Disabled, Medicaid, General Assistance, SSI; or New Jersey Unemployment Assistance. If there is a determination of financial hardship, the fee shall be reduced to $2. Specific instructions on how you or your provider may initiate a Stage 3 external appeal and any necessary forms will be included in the Stage 2 appeal adverse determination notification. You must fill out and sign the forms and mail them, together with the $25 fee (or a $2 fee with evidence of financial hardship) to: Office of Managed Care, Division of Health Care Systems Analysis, P.O. Box 360, Trenton, NJ 08625-0360

Grievance (Reconsideration) Process

If you disagree with a PHS Health Plans decision that is not based on medical necessity, you or someone you designate to represent you can use the PHS Health Plans grievance process to address your concern(s).

Your first step is to call the PHS Health Plans customer service toll-free number on your ID card. If after speaking with a representative you are still dissatisfied with the PHS Health Plans decision, you have the right to file a grievance (request for reconsideration). You have up to six months from the date of the event to file a grievance. A request for reconsideration can be made over the phone by calling the PHS Health Plans customer

service number on your ID card, or by writing to: PHS Health Plans Customer Service Department, 3501 State Highway 66, Neptune, NJ 07754. All written grievances will be decided and reported to you within 30 days of receipt of your complaint at PHS Health Plans.

Provider Compensation Arrangements
Providers in our network have agreed to be paid in various ways by PHS Health Plans. Your provider may be paid: (1) each time he or she treats you ("fee-for-service") or (2) a set fee each month for each member whether or not the member actually receives services ("capitation").

If you desire additional information about how our primary care physicians or any other participating providers are compensated, please call the PHS Health Plans customer service toll-free number on your ID card or write to: PHS Health Plans Customer Service Department, P.O. Box 904, One Far Mill Crossing, Shelton, CT 06484-0944.

Important Information about Referrals
The laws of the State of New Jersey, at N.J.S.A. 45:9-22.4 et seq., mandate that a physician, chiropractor or podiatrist who is permitted to make referrals to other health care providers in which s/he has a significant financial interest inform his or her patients of any significant financial interest he or she may have in a health care provider or facility when making a referral to that health care provider or facility. If you want more information about this, contact your physician, chiropractor or podiatrist. If you believe that you are not receiving the information to which you are entitled, contact the Division of Consumer Affairs in the New Jersey Department of Law and Public Safety at (973) 504-6200 or (800) 242-5846.

Individual Coverage
For more information on individual coverage and eligibility requirements, please write to NJ IHCP, P.O. Box 325, Trenton, NJ 08625, or call (800) 838-0935.

For More Information
Board certification status and new patient availability of participating doctors is available to you upon request. You may also request a copy of the Department of Health and Senior Services report, NJ Managed Health Care Plans Compare Your Choices, at www.state.nj.us/health.

New Jersey Appeal and Grievance Procedures

HMO Consumer Bill of Rights

Consumers have the right to:

- Available and accessible services for urgent or emergency conditions 24 hours a day, 365 days a year;
- Be treated with courtesy and consideration, and with respect for the member's dignity and need for privacy;
- Be provided with information concerning the HMO's policies and procedures regarding products, services, providers, appeals procedures and other information about the organization and the care provided;
- Choose a primary care provider within the limits of the covered benefits and availability, and who are included as participating providers in the plan network;
- A choice of specialists following a referral;
- Obtain a current directory of participating providers, including addresses and telephone numbers, and a listing of providers who accept members who speak languages other than English;
- Be referred to specialists who are experienced in treating their disabilities, if applicable;
- To receive from the member's physician(s) or provider, in terms that the member understands, an explanation of his or her complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives, whether or not these are covered by benefits. If the member is not capable of understanding the information, the explanation shall be provided to his or her next of kin or guardian and documented in the member's medical record;
- Be free from balance billing by providers for medically necessary services that were authorized or covered by the HMO, except as permitted for co-payments, coinsurance and deductibles by contract;
- Formulate and have advance directives implemented;
- All the rights afforded by law or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language the member understands;
- Prompt notification of termination or changes in benefits, services or provider network;
- Know that you or your doctor cannot be penalized for filing a complaint or appeal, and have the right to receive an answer to those complaints within a reasonable period of time;
- Call 911 in a potentially life-threatening situation without prior approval from your HMO;
- Have an HMO pay for a medical screening exam in the emergency room to determine whether an emergency medical condition exists;
- Receive up to four months of continued coverage - if medically necessary - from a health care professional who has been terminated by the HMO (and under certain circumstances continued coverage may be available for a period up to one year);
- Have a doctor make the decision to deny or limit your coverage;
- Know how your HMO pays its doctors, so you know if there are financial incentives or disincentives tied to medical decisions;
- Appeal a decision to deny or limit coverage, first within the HMO, and then through an independent organization (A $25 filing fee applies or upon determination of financial hardship, the fee may be reduced to $2.00.)

Member Appeal Procedure

PHS Health Plans provides two different appeal programs. One program deals exclusively with the PHS Health Plans medical necessity decisions. The second is a grievance program that deals with more general concerns.

Medical Necessity Appeal

If you disagree with a PHS Health Plans decision that a health care service is not medically necessary and appropriate, you or a provider acting on your behalf may request an appeal. A three-stage appeal process is available.

How Your Plan Works

Select Your Primary Care Physician

Your first responsibility as a PHS Health Plans member is to select a *primary care physician (PCP)* from the PHS Health Plans physician and provider directory. Your PCP is your regular doctor and is there to help keep you healthy. Each eligible member of your family can choose his or her own PCP, or you can choose one PCP to handle your whole family. A PCP can be an internist, family or general practice physician, an obstetrician/gynecologist or a pediatrician for your children.

To see whether a physician or provider participates in the PHS Health Plans network, or to check the location and phone number of a network specialist, hospital or urgent care center, you can:

- Refer to the PHS Health Plans physician and provider directory;
- Call the customer service number on your PHS Health Plans ID card. The customer service department also can provide you with information regarding professional qualifications and credentials;
- Visit our web site at *www.phshealthplans.com* for the latest information on participating physicians and providers;
- Call the Interactive Provider Directory system toll-free at **(800) 686-9847** for a personalized list of local participating physicians and providers that can be faxed to you immediately or mailed to your home - just by using a touch-tone phone.

Although as a member in the Charter plan you are not required to obtain a referral from your PCP to see a specialist, we recommend that you always consult your PCP first. Your PCP knows your medical history best and is the most appropriate person to help coordinate all of your health care needs. Please note that a PCP is someone you can call at any time. All offices have answering services that can immediately contact your PCP or another physician who is on call should you have a health concern after office hours.

If you are not sure whether your concern warrants a call to your PCP, you can call the PHS Health Plans Personal Health Advisor™ 24 hours a day, seven days a week at **(800) 219-5326.** A registered nurse will assess your symptoms and assist you in determining the appropriate level of care.

Whenever you call your physician's office, be sure to identify yourself as a PHS Health Plans member. Check your ID card for the office co-payment that may be required at the time of your visit. In most cases, you will not receive a bill for services from participating physicians and providers.

Changing Your PCP

A good relationship with your doctor develops over time, so it's not a good idea to change your PCP frequently. However, if you or any of your eligible dependents need to change a PCP for any reason, call or write to the PHS Health Plans customer service department to advise us of the name of the new doctor. Your change will be effective immediately. If your PCP terminates from the PHS Health Plans network for any reason, you will receive notification from PHS Health Plans approximately 30 days before the date of termination, and you will be asked to choose another PCP.

Covered Services

PHS Health Plans covers necessary preventive health care. This also includes physical exams, well baby care, immunizations, family planning services and clinical laboratory and radiology testing. Please refer to your plan documents for a more detailed explanation of covered preventive services. These covered services may have maximum benefit limits or a co-payment.

To be considered a covered service, all services and supplies must be: 1) expressly set forth as a covered service in the plan documents or an amendatory rider and 2) for certain covered services, must have received prior authorization from PHS Health Plans.

Medical Services

PHS Health Plans also provides benefits for certain medically necessary and appropriate services. You are entitled to discuss all treatment options with your practitioner, including noncovered services or experimental treatments. If PHS Health Plans determines that the services were not medically necessary or appropriate, the claim will be denied. Please refer to your plan documents for a more detailed explanation of medical services.

Medically Necessary Defined

Medically necessary services include health care services or supplies, including the prevention, diagnosis or treatment of a medical condition. Services must also meet all of the following requirements and must not be excluded or limited by your plan documents:

- Services that are appropriate for and consistent with the symptoms and proper diagnosis or treatment of the member's illness, injury, disease or condition;
- Services provided for the diagnosis or the direct care and treatment of the member's illness, injury, disease or condition;
- Services that are not primarily for the convenience of the member or anyone else;
- Services that meet the standards of good medical practice within the organized medical community;
- Services that are neither experimental nor investigational;
- Services that meet the most appropriate supply or level of service that can safely be provided (For hospital stays, this means that acute care as an inpatient is necessary due to the type of covered services a member is receiving or the severity of the member's condition, and adequate care cannot be received as an outpatient or in a less intensive medical setting.)

Specialty Care

As a PHS Health Plans member, you may request access to a specialist to coordinate your care or access to a specialty care center if you have a life-threatening or degenerative and disabling condition or disease which requires specialized medical care over a prolonged period of time. Specialty care may be accessed in accordance with the terms of your plan documents. For more information, please call the customer number on your ID card.

For New York Enrollees Only:

This member handbook is pending approval by the New York Department of Health. Any material changes will be communicated to you.

Charter Point-of-Service (POS) Plan

In the Charter Point-of-Service (POS) plan, you decide each time you seek medical care whether you want to use a participating or nonparticipating physician and provider. You may stay in-network and receive maximum benefits, or go out-of-network and be subject to deductible, coinsurance, usual, customary and reasonable (UCR) charge limitations, and claim forms. When you use covered out-of-network services, you are also responsible for obtaining prior authorization for inpatient admissions, outpatient surgery and other designated services.

If you are unsure whether a physician or provider participates with PHS Health Plans, you can:

- Refer to the PHS Health Plans physician and provider directory;
- Call the customer service number on your ID card;
- Visit our web site at www.phshealthplans.com;
- Call our Interactive Provider Directory system at **(800) 686-9847** for a personalized list of local participating physicians and providers that can be faxed or mailed to you - just by using a tone-tone phone.

Your choice of a participating or nonparticipating physician and provider affects your level of coverage. Please see the following comparison:

In-Network

If you receive covered services from your PCP or from a participating specialist, you are eligible for in-network benefits. This means your coverage has:

- No deductible
- No coinsurance
- No claim forms to complete
- Full coverage, less your co-payment responsibility
- Preventive services

Out-of-Network

If you receive covered services from a nonparticipating physician or provider, you are eligible for out-of-network benefits.* In these situations, you are responsible for:

- Deductible
- Coinsurance
- The difference between the physician's or provider's billed amount and the UCR
- Submitting medical claim forms
- Payment for some preventive services**
- Obtaining prior authorization for inpatient admissions, outpatient surgery and other designated services

* Except in cases of true medical emergency

** Please refer to your plan documents for specific details of your plan's coverage or call our customer service department.

The Charter POS plan provides benefits for covered services whether you use participating or nonparticipating physicians and providers. However, by using participating physicians and providers for your care, you can significantly reduce your expenses. Please see below for an illustration.

Here is an example of what the difference in cost can be for a member with a $300 individual deductible and 80/20 coinsurance when elective outpatient surgery is done out-of-network rather than in-network. In-network costs may be as little as $0 if there is no co-payment.

Out-of-network costs for a $2,500 procedure would be:

Provider's Billed Amount	$2,500
Allowable Amount (UCR)	- $2,000
Difference in UCR	$ 500
(Member is responsible for this charge)	
Allowable Amount (UCR)	$2,000
Applicable Plan Deductible	- $ 300
Subtotal	$1,700
Applicable Plan Coinsurance	X 80%
PHS Health Plans Payment	$1,360
Member's responsibility	$ 340

Member Cost Summary:

Difference in UCR	$ 500
Deductible	$ 300
Coinsurance	+ $ 340
Member's Total Cost	$1,140

Please refer to your plan documents for a complete, detailed description of in-network and out-of-network benefits, including limitations and exclusions.

Usual, Customary and Reasonable (UCR) Charges

Payment for covered services out-of-network is based on usual, customary and reasonable (UCR) charge limitations, except in cases of emergency. UCR is based largely on data compiled and reviewed by outside agencies, which determine customary charges for services within a certain geographic location. The charges will vary by provider specialty and specific service(s) rendered. UCR allows us to keep your premium at an affordable level and is used by almost all insurers for out-of-network expenses. UCR represents our "allowed amount" or "allowed charges" for out-of-network services.

customary charges or provider billed amt

Deductible

Depending on the plan your employer has selected, some services you receive will involve co-payments and/or deductible and coinsurance. Before we will make payments for covered out-of-network services, you and/or your eligible dependents must meet the annual deductible dollar amount for your plan. The deductible amount that your employer group selected is listed in your plan documents and is applied on a calendar year (January 1 through December 31) basis.

Coinsurance

After you meet your deductible, we will share the costs for out-of-network services. This cost-sharing is called coinsurance. The coinsurance amount is also selected by your employer, and your payment responsibility includes your coinsurance amount, as well as all charges in excess of our allowed charges (UCR).

Out-of-Pocket Costs

Also listed in your plan documents are your individual and family out-of-pocket maximums. Once your out-of-pocket maximum for deductible and coinsurance is met, we will provide full coverage up to our allowed amount for eligible out-of-network services. Charges you pay in excess of our allowed amount are not counted toward your deductible or out-of-pocket maximums. Also, penalties, if applicable, applied for failure to get prior authorization for applicable out-of-network services do not count toward deductible, coinsurance or out-of-pocket maximums.

Prior Authorization

Members enrolled in the Charter POS plan who elect to receive care from a nonparticipating physician or provider are responsible for contacting PHS Health Plans to begin the prior authorization process.

Filing a Claim

Call customer service immediately if you receive a bill for covered services that you believe should have been paid by PHS Health Plans.

Members who choose to receive services from a nonparticipating physician or provider must file a claim within **six months** of the date of service and complete an out-of-network questionnaire. Please specify on the out-of-network questionnaire if you have paid for the out-of-network services. PHS Health Plans will reimburse you directly according to the provisions of your plan documents. If you have already paid the provider, please be sure not to assign the benefits to the provider on the claim form because your reimbursement will then go directly to the provider, and you will have to collect payment from the provider's office.

What To Do In An Emergency

Emergencies can strike at any time and anywhere. A true medical emergency is the sudden and unexpected onset of a condition in which delay in treatment would endanger your health or life.

Examples of this include:

- Difficulty breathing
- Burns
- Excessive bleeding
- Acute stomach pain
- Sudden change in mental state (e.g., disorientation)
- Unconsciousness
- Broken bones
- Suspected heart attack
- Shock

As a PHS Health Plans member, you are covered whenever and wherever you need urgent or emergency care. The following are procedures you must follow to ensure that care for emergency services will be covered. Services in a true emergency do not require prior approval or authorization by your PCP.

If you are faced with a medical emergency:

- Go straight to the emergency room or call 911;
- Call your PCP or a participating physician for medical direction. If time does not permit a call to your PCP, either dial 911 or go to the nearest hospital. Contact your participating physician as soon as possible to help with any follow-up care;
- If you are not sure whether your situation qualifies as an emergency, call the PHS Health Plans Personal Health Advisor™ at **(800) 219-5326.** The advice line is a free service, available 24 hours a day, seven days a week. When you call, a registered nurse will assess your symptoms and assist you in determining the appropriate level of care;
- Contact PHS Health Plans within 24 hours, or as soon as reasonably possible, if you are admitted to the hospital as a result of an emergency.

Please note that you will have to pay a portion of the bill (emergency room co-payment if applicable) for all covered visits to the emergency room, even if your PCP or any other participating doctor referred you. If you are admitted to the hospital directly from the emergency room, however, the co-payment is waived. Although PHS Health Plans will cover emergencies anywhere, follow-up care in the emergency room will not be covered. Please remember that you will be responsible for bills for emergency room services that are determined to be not true emergencies.

Out-of-Network/Out-of-Area Emergencies

There are times when an emergency occurs outside of the PHS Health Plans service area. Examples of this include:

- Vacations
- Foreign travel
- Students away at school

If an emergency occurs while you are away from home, or if emergency services are provided by a nonparticipating hospital, these simple steps will ensure your treatment is reviewed for coverage:

- Follow the suggestions listed above for an emergency;
- Ask the hospital to bill PHS Health Plans directly for your treatment. If this is not possible and you are asked to pay for services up front, obtain an itemized bill and submit it to PHS Health Plans with an out-of-network claim questionnaire;
- If you are in a foreign country and have an emergency, ask for the itemized bill to be converted to United States currency and the services rendered to be translated into English. If this is not possible, PHS Health Plans can have it done for you.

If your college student who is a covered dependent has a true medical emergency, emergency care is covered at any local hospital emergency room or infirmary. Follow-up care outside of the PHS service area without prior authorization is not a covered benefit.

Continuing or Follow-Up Treatment

PHS Health Plans will provide in-network benefits for services rendered at a nonparticipating hospital by a nonparticipating physician only when the continued hospitalization is medically necessary and your medical condition prevents your transfer to a participating hospital.

If the services are not medically necessary, no additional benefits will be provided. If your condition is such that you could be transitioned to a participating hospital, the services will not be covered at the nonparticipating hospital.

Any necessary follow-up treatment, such as physical therapy, removal of stitches, wound check (or other services initially provided in the emergency room) must be coordinated through your PCP and must be authorized in advance by PHS Health Plans to be covered as an in-network benefit.

Urgent Condition

An urgent condition is different from an emergency in that it is not as serious, but you still need to access your doctor right away. If you have an urgent problem, call your PCP or treating physician. Your doctor may give you first-aid advice or tell you to go to his or her office, a covering physician's office, an urgent care center or the hospital emergency room.

Enrollment and Eligibility

Keep Us Informed

Any time there are changes regarding your name, home address or family status, you should immediately notify PHS Health Plans or the contact designated by your employer. If you are enrolled through an employer, please contact your benefits manager as well. He or she must then submit a completed PHS Health Plans enrollment/change form.

Coverage for Family Members

Family members may be added or deleted from your policy during open enrollment. You may also make changes to your coverage within 31 days of a qualifying event as long as your employer approves the change, and the change meets PHS Health Plans eligibility criteria. (Qualifying events include marriage, divorce, birth, adoption, death or loss of coverage through your spouse's insurance carrier.) For a more detailed explanation of eligibility and effective date, please refer to your plan documents.

For more information on individual coverage and eligibility requirements, please write to the Health Reinsurance Association (HRA), 450 Columbus Boulevard, 9NB, Hartford, CT 06115-0450, or call **(800) 842-0004**.

Continuation of Coverage

Check with your benefits manager or plan administrator if you wish to continue your PHS Health Plans membership after you leave your job or if you decrease your work schedule to the point where you are no longer eligible for health coverage.If you are receiving benefits through COBRA, or other continuation of coverage provisions, you may be required to pay a monthly premium to your employer.

For complete information on continuing your PHS Health Plans membership, please check your plan documents or call the customer service number on your ID card.

Coordination of Benefits (COB)

When You Are Covered By Other Health Plans

As the number of dual-income households with duplicate health coverage increases, so does the need to coordinate benefits between health plans. Rather than have two plans possibly pay more than the cost of care, health plans and insurers follow rules to determine which health plan or insurer pays first (primary payer) and which pays second (secondary payer).

If you or your spouse is covered by more than one plan, PHS Health Plans and the other company will coordinate benefits so that payments are not duplicated. The primary plan pays for covered services first. The secondary plan pays the remaining unpaid allowable expenses. No plan pays more than it would have for services without this coordination of benefits provision.

Under COB rules, your employer's plan is your primary plan, and your spouse's plan is secondary. Likewise, the plan your spouse gets from his or her employer is primary for him or her, and yours is secondary. For dependent children covered under both plans, the birthday rule determines which is primary. The parent whose birthday falls earlier in the year is the one whose plan pays first. When parents are divorced, the coverage of the parent with physical custody of the child is primary, unless the separation agreement or divorce decree specifies that one parent has responsibility for the child's medical expenses.

When you have dual coverage, PHS Health Plans must be aware of the other plan to provide benefits. When you enrolled in PHS Health Plans, you were asked to identify any other group plans that cover you. If you have been added to or terminated from another plan since you originally enrolled in PHS Health Plans, call the customer service number on your PHS Health Plans ID card to update your records. Please remember that even when PHS Health Plans is the secondary payer, you will only be covered if you adhere to the rules of the plan in which you are enrolled, for example, obtaining prior authorization if necessary.

When PHS Health Plans is the secondary payer, show your ID card to the participating physician's or provider's office staff. Ask them to bill PHS Health Plans after they receive payment from the primary payer. The only payment you will be required to make is any applicable co-payment.

Workers' Compensation

Medical services required for injuries occurring at work should be submitted to your employer's workers' compensation insurance company. If the workers' compensation claim is denied, you may be covered by PHS Health Plans as long as you have used participating physicians and providers and have followed the appropriate prior authorization procedures. Claims must be submitted within 18 months of the date of service to be considered for coordination with workers' compensation benefits.

Automobile Accidents

Medical claims resulting from an automobile accident or contact with a car should first be sent to the auto insurer for verification of medical coverage. This verification must accompany any claim submission to PHS Health Plans. Claims must be submitted within 18 months of the date of service to be coordinated with the medical benefits provision of your automobile insurance policy.

Mental Health and Substance Abuse

If you have mental health and substance abuse coverage with PHS Health Plans, please refer to your plan documents for a complete description of the benefits, including limitations and exclusions. If you have any questions, please call the customer service number on your ID card.

Out-of-Plan Referrals/Prior Authorization

There are times when PHS Health Plans needs to be notified about your health care before you receive certain services. There are two types of authorizations, and each is required for different circumstances. They are:

- Out-of-plan referrals for services that are not available through the PHS Health Plans physician and provider network;
- Prior authorization for certain covered services.

Out-Of-Plan Referrals

In the Charter POS plan, you have out-of-network benefits. Services that are not available through the PHS Health Plans physician and provider network must be authorized in advance to be covered in-network. It is your responsibility to obtain approval from PHS Health Plans before seeking care from a nonparticipating physician or provider. If PHS Health Plans denies your out-of-plan referral request, you can choose to use your out-of-network benefits.

Prior Authorization

Certain services and procedures require prior authorization to ensure that they are medically necessary and appropriate. Please refer to your plan documents for a detailed description of services that require prior authorization. When you are obtaining services in-network, your participating physician will request prior authorization for all elective admissions, as well as some outpatient surgical procedures and other designated services. If you are enrolled in the Charter POS plan, it is your responsibility to obtain prior authorization for services from nonparticipating physicians and providers, and for all out-of-network outpatient surgical procedures. The service must be approved before it is rendered to receive coverage. You, or a provider acting on your behalf, may call the PHS Health Plans prior authorization department at **(800) 438-7886.** You will be notified of any denials.

Utilization Review

Utilization Review (UR) will occur pertaining to the prior authorization of health care services. UR nurses are available 24 hours a day, seven days a week to receive calls regarding UR determinations. You, or a provider acting on your behalf, may call the PHS Health Plans prior authorization department at **(800) 438-7886** to request a UR determination.

Member Rights and Responsibilities

PHS Health Plans is committed to treating members in a manner that respects their rights, and to providing access to quality health care. These are your rights and responsibilities as a member:

- You have a right to receive information about PHS Health Plans, its physicians and providers, and your member rights and responsibilities;
- You have the right to be treated with respect and recognition of your dignity and right to privacy;
- You have the right to participate with providers in the decision-making process regarding your health care without restriction;
- You have the right to voice a complaint or appeal about PHS Health Plans or the care provided;
- You have a right to a candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage;
- You have a responsibility to provide, to the extent possible, information that PHS Health Plans and its providers need to care for you;
- You have a responsibility to follow plans and instructions for care that you have agreed upon with your providers.
- You have a right to obtain complete and current information concerning a diagnosis, treatment and prognosis from a physician or other provider in terms that you can understand;
- You have a right to receive information from a physician or other provider that is necessary to give informed consent before the start of any procedure or treatment;
- You have a right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of such action;
- You have a right to formulate an advance directive regarding your care.

Confidentiality

PHS Health Plans recognizes the importance of trust between the health plan and its members, and understands the importance of safeguarding all member medical and/or personal information. PHS Health Plans treats access to member medical records with utmost respect and confidentiality, and complies with the applicable confidentiality statutes in its coverage area.

Use of a member's personal health information for any purpose must be authorized by clear and specific consent provided by the member, unless release of the information is required by law. Members consent to the release of medical information to PHS Health Plans on their enrollment forms. At the time of enrollment, PHS Health Plans obtains consent for the use of identifiable information that is needed for treatment, coordination of care, conducting quality assessment, utilization review, fraud detection, and oversight reviews conducted by state and federal agencies.

Member information is released only to the member, including medical records, appointment information and test results. Member information cannot be released:

- To the member's spouse or any other family member without the member's consent;
- To the parent regarding an adult child without the member's consent;
- Without specific authorization if the information is sensitive and/or legally protected.

PHS Health Plans associates with access to medical information are trained in the standards and behaviors incumbent with this privilege. Associates may use or disclose medical information only as necessary for authorized administrative purposes if authorized by the member or when required by law. This information is highly sensitive and requires thoughtful and attentive management by those who have access to it. All associates are obligated to protect members' rights to privacy and to safeguard the clinical information contained in the medical records.

To ensure that personal information is protected, all PHS Health Plans associates are required to sign a confidentiality statement. Anyone who has access to confidential information must review the same confidentiality statement and acknowledge in writing that they understand and will abide by the policy.

PHS Health Plans trains associates to be sensitive to confidentiality concerns and to comply with confidentiality policies. Associates are required to read the PHS Health Plans confidentiality policy and acknowledge in writing that they understand and will abide by the policy. Associates are expected to strictly adhere to the guidelines without exception.

Every physician and provider contract also contains a confidentiality statement. PHS Health Plans evaluates record-keeping practices before the providers are admitted to its network.

Technology Assessment

PHS Health Plans Medical Directors and practicing physicians are part of a nationwide approach by our parent company to continually assess new technology. Research and current scientific evidence should demonstrate appropriate and effective use of the technology. If PHS Health Plans determines that the new technology will have a positive effect on health outcomes and is not a contractually excluded service, it will be considered for coverage.

Payer Arrangements

The relationship between PHS Health Plans and its participating physicians and providers is that of independent contractors. Participating physicians and providers operate their own offices and businesses, and make their own medical decisions. The services they provide are not exclusive to PHS Health Plans and its members. Participating physicians and providers maintain the provider-patient relationship and are solely responsible to members for all medical services rendered by them.

Participating physicians and providers agree to methods and rates of payment from PHS Health Plans and agree to the PHS Health Plans medical management procedures. No contract between PHS Health Plans and any participating physician or provider shall prohibit the provider from disclosing to a member the method that PHS Health Plans uses to compensate him or her.

No participating physician or other provider, institution, facility or agency is a PHS Health Plans agent or employee. Neither PHS Health Plans nor any employee is an agent or employee of any participating physician or other provider institution, facility or agency.

PHS Health Plans contracts with physicians and providers either directly or through provider organizations (IPAs and PHOs). Most of these providers are reimbursed for each covered service on a fee-for-service basis with a limited percentage withheld as a reserve. However, some IPAs or PHOs may reimburse their primary care providers on the basis of a set amount per member per month (capitated reimbursement). Depending upon the overall utilization of members selecting PHS Health Plans directly contracted or an IPA's/PHO's primary care providers, the amount withheld by PHS Health Plans may be returned to the providers.

PHS Health Plans also contracts with certain vendors and suppliers (laboratory services, home health, etc.) that are paid a capitated reimbursement. Hospitals and other institutional providers are reimbursed according to per diem rates, case rates or discounted fee-for-service arrangements.

The PHS Health Plans medical management procedures are intended to ensure the medical necessity and appropriateness of treatment and to actively discourage any barriers to care. PHS Health Plans does not financially compensate or otherwise encourage physicians, providers or other individuals involved in medical management for denying covered services.

In addition, PHS Health Plans has entered into per member per month-based payment arrangements for the provision of mental health, home care, laboratory and chiropractic services. The provider reimbursement models are designed to ensure that providers are paid appropriately for services rendered. These reimbursement models also support the goals of the plan by providing members with the right care at the right location by the right provider at the right time. None of these provider contracts prohibit providers from discussing compensation arrangements with their patients.

Member's Relationship with PHS Health Plans

A member's contractual relationship with PHS Health Plans does not prevent the member from obtaining services that are not covered under the terms and conditions of the plan documents. PHS Health Plans has no direct control over the examination, diagnosis or treatment of any member. PHS Health Plans does, however, perform medical management procedures for the purpose of determining appropriate coverage for the services provided to members. Our medical management programs are designed to encourage the most appropriate care for each member. PHS Health Plans does not arbitrarily nor indiscriminately deny medically necessary covered services. Decisions are based on prevailing standards of medical care in accordance with the member's plan documents. These procedures are not intended to create a physician-patient relationship nor to replace the relationship between a member and his or her own physician. A member is always entitled to obtain, at his or her own expense, services that are not covered under the terms and conditions of the plan documents. At all times, PHS Health Plans employs reasonable care in the exercise of its power and in the performance of its obligations to ensure that members consistently receive high-quality care.

Well Exam Schedule

Routine* Pediatric Health Examinations and Immunizations:

- Birth to the attainment of one year of age, a total of six** routine pediatric examinations
- One year of age to the attainment of two years of age, a total of three routine pediatric examinations
- Two years of age to the attainment of 19 years of age, one routine pediatric examination per calendar year

Routine* Adult Health Examinations:

(according to the recommendations of the American Academy of Family Physicians)

- 19 years of age through 29 years of age, one routine examination every five calendar years
- 30 years of age through 39 years of age, one routine examination every three calendar years
- 40 years of age through 49 years of age, one routine examination every two calendar years
- 50 years of age and over, one routine examination per calendar year

* Routine exams are covered in-network only unless otherwise specified in your plan documents.

** New York State law requires seven routine pediatric examinations.

PHS Health Plans Healthy Extras

Here's how to access the PHS Health Plans program of value-added services

Healthy Extras* include:

- PHS AlternaCare℠
- Personal Health Advisor
- Directory By Phone
- Directory By Web
- Smart Start℠
- WellBaby℠
- Well Woman for Life
- Disease Management (including asthma and diabetes) Programs
- Fitness Center Discount Program

PHS AlternaCare℠

Our AlternaCare℠ program offers quality, affordable, holistic health care options for PHS Health Plans members. This includes coverage for chiropractic and acupuncture** treatments with co-payments, and discounts for massage therapy.

For chiropractic and acupuncture treatments and massage therapy, choose participating providers from our physicians and provider directory. For the most up-to-date list, visit our web site at *www.phshealthplans.com* or call the Interactive Provider Directory, toll-free, **(800) 686-9847.** For more information on holistic health care, call, toll-free, **(800) 638-4557.**

* Program is subject to change or termination without prior notice.

** Some employers may have purchased a plan for their employees that does not include acupuncture benefits. Please refer to your plan contract or call the customer service number on your ID card.

Personal Health Advisor™

Our free Personal Health Advisor™ phone line is available 24 hours a day, seven days a week to answer your health-related questions. If you are sick or have been hurt, and are unsure of what to do, a specially trained nurse can help you determine the most appropriate course of action. The 550 nurses that staff the phones average more than 15 years of clinical experience. Together, they handle 2 million calls every year. If you ever need help assessing an injury or illness, call the Personal Health Advisor™ toll-free, **(800) 219-5326.**

Directory By Web/Directory By Phone

Even when you do not have access to our printed directory, you can still locate a participating physician or provider. Our Directory By Phone enables you to have a personalized list of local physicians or providers either faxed to you immediately or mailed to your home. The system will find 100 closest to the zip code you supply. Our Directory By Web allows you to create a customized directory from our web site. To access the Directory By Phone, call toll-free, **(800) 686-9847.** To access the Directory By Web go to our web site, *www.phshealthplans.com.*

Smart Start℠

PHS Health Plans now offers an immunization reminder program - Smart Start℠ - for children from birth to two years old. Parents will receive a postpartum mailing about the program containing the following:

- An explanation of the Smart Start℠ program
- A handy refrigerator magnet with the immunization schedule
- An "America's Youth Passport™" containing health and safety tips
- An Immunization RecordKeeper form

Included is a complimentary portrait package gift certificate if the child has received all of his or her immunizations by age two. When a newborn is added to the health plan within 31 days of his or her birth, the baby is automatically enrolled in Smart Start℠.

WellBaby℠

WellBaby is a *free* prenatal-care program that complements your obstetrician's advice and care. Once you are enrolled in the program, a nurse will complete a questionnaire with you over the phone. Based on your responses, health professionals can alert you and your doctor to any potential problems, and help you monitor your pregnancy and your baby's health. As a member of the WellBaby program, a nurse is available to answer your questions 24 hours a day, seven days a week. In addition, enrollment in the WellBaby program entitles you to a free copy of *Baby and Me, the Essential Guide to Pregnancy.* Joining the WellBaby program is easy - just call, toll-free, **(800) 813-2575.**

Well Woman for Life

Well Woman for Life, the PHS Health Plans healthy woman program, offers reminder mailings to female members for mammograms and cervical cancer screenings.

Mammograms: Have you had your mammogram lately?

PHS Health Plans covers female members in full for mammograms at participating providers. You should have your first mammogram (baseline) at age 35. This is especially critical if there is a history of breast cancer in your family. If you are age 40 to 49, you should have a mammogram every one to two years, based on your doctor's recommendation. If you are age 50 or more, you should have a mammogram annually. Your doctor or a PHS Health Plans customer service representative can help you locate a participating provider.

Pap Tests: Early detection is your best defense

If you are female, age 19 or older, or sexually active, PHS Health Plans recommends an annual Pap test. This screening is a covered benefit and can detect cervical cancer in its earliest and most curable stage. Osteoporosis and menopause education materials also are available. If you have any questions, call the PHS Health Plans customer service number on your ID card.

Disease Management Programs

Disease Management programs help members manage their chronic conditions. When you are facing the challenges of diabetes, congestive heart disease, asthma, glaucoma, osteoporosis, kidney disease and other chronic conditions, we can help with our education and care-management program. For more information, call toll-free, **(800) 573-2177.**

Fitness Center Discount Program

Regular exercise is fundamental to good health and well being. To help you become or stay fit, PHS Health Plans offers discounted memberships to an extensive network of fitness centers in the tri-state area. The program is administered by WellQuest, Inc. You will find a list of participating centers in our directory of physicians and providers. A one-time registration fee ($40 for you, $20 for each additional family member) entitles you to a discount of up to 30 percent off the monthly fee at a network fitness center of your choice. Membership also entitles you to use any other participating facility up to four times per month (16 times per year, per center). For more information call WellQuest, toll-free, **(800) 595-8448.** Be sure to consult a physician before beginning any fitness program.

We Want to Hear from You!

At PHS Health Plans, our goal is to continuously improve the quality of care and service that members receive. If you have a suggestion about our service, or a complaint about the care you received from a participating physician or provider, we want to know. Please call the customer service number on your ID card or send an e-mail to ***member@phshealthplans.com.*** You also can write to PHS Health Plans, Attn: Customer Service Department, One Far Mill Crossing, P.O. Box 904, Shelton, CT 06484-0944.

How to Reach Us

Customer Service
1-800 956-5565
PHS AlternaCare℠
Administered by Landmark Healthcare
(800) 638-4557

Fitness Center Discount Program
Administered by WellQuest
(800) 595-8448

WellBaby℠
(800) 813-2575

Disease Management Programs
(800) 573-2177

Personal Health Advisor→
(800) 219-5326

Directory By Phone
(800) 686-9847

Directory By Web
www.phshealthplans.com

E-mail
Member@phshealthplans.com

PHS Health Plans Web Site
www.phshealthplans.com

Out-of-Network Claims Questionnaire

Please provide all of the requested information below. Remember to attach an itemized bill for each out-of-network claim you are submitting for review. If you have any questions, please call the customer service number on your PHS Health Plans ID card.

phs health plans

1. Patient's PHS Health Plans ID= __ __ __-__ __-__ __ __ __	2. Patient's Date of Birth __ __ / __ __ / __ __
3. Patient's Name	4. ☐ Male ☐ Female
5. Member's Address City State Zip	
6. The **daytime phone number** where you may be reached if we have more questions: (__ __ __) __ __ __-__ __ __ __	
7. Is the patient a full-time student out of the service area? ☐ Yes ☐ No	

8. If the attached claim has been caused by an **automobile accident,** please submit this and all related claims to your No-Fault insurance carrier.

   If the attached claim has been caused by the **patient's employment,** please submit this and all related claims to the employer's Worker's Compensation carrier.

   If PHS Health Plans is your **secondary insurance plan,** please submit this claim to your primary insurance carrier.

   Once a determination has been made by either No-Fault, Worker's Compensation or another primary insurance carrier, submit a copy of the original bill and a copy of their explanation of benefits to PHS Health Plans for further consideration.

9. Please provide a detailed explanation as to the **specific nature of illness or injury** and **why a PHS Health Plans physician/provider was not utilized.** (Please attach additional pages if needed.)

   _____

   _____

10. If you want us to pay covered benefits directly to the provider, sign and date the authorization below. If authorized, we will make payment directly to your provider and send a copy of the payment to you for your records.

I authorize payment of medical benefits **directly** to physician or supplier for attached services.

Signed _____ Date _____

Please send claims and written inquires to:

PHS Health Plans
Attn.: Out-of-network Claims Department
P.O. Box 981
Bridgeport, CT 06601-0981

Members: If you have any questions regarding claims please call the customer service number on your ID Card.

Providers: Call **(800) 438-7886**

Note: Claim information should be submitted on a completed HCFA-1500 or UB-92 form.

THE GUARDIAN & PHS HEALTHCARE SOLUTIONS
HMO-POS PLAN
SMALL GROUP HEALTH MAINTENANCE ORGANIZATION
PASSPORT POINT OF SERVICE
EVIDENCE OF COVERAGE

Physicians Health Services of New Jersey, Inc. ("PHS") certifies that the Employee named on The Guardian & PHS Healthcare Solutions Member Identification Card is entitled to the services, supplies and benefits described in this Evidence of Coverage, as of the Effective Date shown on The Guardian & PHS Healthcare Solutions Member Identification Card carrier sheet, subject to the eligibility and effective date requirements of the Contract.

The Contract is an agreement between PHS and the Contractholder. This Evidence of Coverage is a summary of the Contract provisions that affect Your coverage. All coverage is subject to the terms and conditions of the Contract.

Physicians Health Services of New Jersey, Inc.

Barry Averill

By: Barry Averill
President

2000
Rev. 7/00
NJ G/PHS 5NJSPZF
NJ G/PHS 5NJSCZF
EOC

Copay Schedule J50285
Contract type: JGJ
JG2

INTRODUCTION

What is a Point of Service Plan?
A Point of Service Plan, often referred to as a POS plan, provides coverage for the services of ***in-network providers*** as well as the services of ***out-of-network providers.*** Whenever a person covered under a POS plan needs to access health care, he or she has the option to use the services of either an ***in-network provider*** (subject to any necessary authorization from his or her Primary Care Physician) or those of an ***out-of-network provider.***

What is the difference between an in-network provider and an out-of-network provider?
An ***in-network provider*** is a doctor, other practitioner or facility that has an agreement with PHS to provide or arrange for covered services and supplies for the benefit of persons covered under the POS plan. An ***out-of-network provider*** is any licensed or certified provider that does not have a specific agreement with PHS.

Generally, the out-of-pocket cost to a person covered under a POS plan will be less if the person uses the services of an ***in-network provider*** rather than the services of an ***out-of network provider.***

How does the POS plan describe in-network and out-of-network coverage?
The POS plan contains a section which describes in-network coverage and sections which describe out-of-network coverage. The POS plan also contains many sections which apply to both the use of the services of ***in-network providers*** or the services of ***out-of-network providers.***

- **SCHEDULE.** Located in the beginning of the POS plan, the SCHEDULE identifies many of the covered services and supplies and specifies the applicable copayment for use of an ***in-network provider*** as well as the deductible and coinsurance requirement for the use of an ***out-of-network provider.*** The **SCHEDULE** also identifies some limitations to coverage.

- **COVERED SERVICES AND SUPPLIES.** This section contains a general description of the coverage a person would be entitled to if he or she were to use the services of an ***in-network provider.***

- **COVERED CHARGES** and **COVERED CHARGES WITH SPECIAL LIMITATIONS.** These sections contain descriptions of the coverage a person would be entitled to if he or she were to use the services of an ***out-of-network provider.***

How does a person access in-network providers?
PHS will provide a directory listing all the Primary Care Physicians and facilities that have an agreement with PHS. Each person must select a physician from that directory to be his or her Primary Care Physician, also called a PCP. The PCP supervises, coordinates, arranges or provides care, and refers a person for specialist services, as appropriate. The person may name a new PCP by notifying PHS.

Except in case of a medical emergency, in-network services and supplies can **only** be provided by an ***in-network provider*** (subject to any necessary authorization from his or her Primary Care Physician). While certain routine OB/GYN care may be secured without going through the PCP, all other in-network services and supplies require the authorization of the PCP.

How much will it cost for services and supplies if a person uses in-network providers?
The Identification Card will specify the amount of the copayment the ***in-network provider*** will collect for most services and supplies. For many services, after a person pays a copayment for the PCP visit, further services and supplies require no additional payment. Home Health Care and Durable Medical Equipment are examples of such services and supplies. PHS elected to cover prescription drugs subject to the same copayment as the applicable office visit copayment.

For example, if the POS plan required a $15 physician visit copayment, this amount would be collected from the patient, regardless of the reason for the visit and the actual cost of the services provided during the visit.

Are there restrictions on the use of an out-of-network provider?
Persons covered under a POS plan may use the services of an out-of-network provider as often as they like, subject to applicable benefit limitations. Referral from a PCP is not required, but certain services and supplies do require Pre-Approval from PHS, as outlined in the Contract and Evidence of Coverage.

How much will it cost for services and supplies if a person uses out-of-network providers?
After the payment of the applicable calendar year cash deductible, the person would be responsible for payment of the plan's coinsurance.

For example, assume a POS plan with out-of network benefits subject to a $250 deductible and 20% coinsurance. A person may go to a physician for a sick visit with total charges equal to $350. If the physician visit is the first out-of network charge for the year, the person would first be required to pay $250 to satisfy the deductible. Then, PHS would pay 80% of the remaining $100 charges, or $80. The person's coinsurance share would be 20% of $100, or $20. Thus, the total cost to the person would be $270. After the deductible has been satisfied during a calendar year, further charges are only subject to the applicable coinsurance. **Note:** PHS pays the applicable coinsurance with respect to the lesser of: a) the amount charged; or b) the Reasonable and Customary Charge, as defined in the Contract and the Evidence of coverage.

Does the POS plan cover the same services and supplies whether a person uses in-network providers or out-of-network providers?

The POS plan was designed to include the same services and supplies whether the person uses ***in-network*** or ***out-of-network providers.*** However, the **extent** of coverage differs for some services and supplies. For example, if a person elects to use an ***in-network provider*** for extended care services (skilled nursing care), coverage is unlimited as to number of days. If a person uses an ***out-of-network provider,*** extended care services are limited to 120 days.

Since in-network services and supplies must be coordinated by a PCP, and ***in-network providers*** are familiar with in-network covered services and supplies, the list of in-network covered services and supplies in a POS plan does not generally include as much detail as the list of out-of network covered charges. In addition, PHS is able to offer more details as to the nature and extent of the in-network coverage.

For services and supplies that are subject to limitations, can a person receive both in-network and out-of-network services and supplies?

The POS plan allows a person to receive any combination of in-network and out-of network services and supplies. However, for services and supplies subject to limitations, the POS plan includes offset provisions to coordinate the **total** services and supplies a person may receive.

PLEASE REFER TO THE CONTRACT AND EVIDENCE OF COVERAGE FOR COMPLETE INFORMATION CONCERNING THE POS PLAN AND USE OF IN-NETWORK AND OUT-OF-NETWORK PROVIDERS.

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SCHEDULE OF CLASSIFICATION

The Contract's classification, and the coverages and amounts which apply to each class are shown below:

CLASS
All eligible employees

OVERVIEW OF THE PLAN (Copayment, Deductibles, and Coinsurance)

IN-NETWORK	
Copayment	$5, unless otherwise stated
Emergency Room Copayment	$50, credited toward Inpatient admission if admitted within 24 hours
Coinsurance	0% except as stated on the Schedule of Covered Services and Covered Supplies

OUT-OF-NETWORK	
Calendar year Cash Deductible (All Cause)	
for Preventive Care	NONE
for immunizations and lead screening for children	NONE
for all other Covered Charges	
Per Covered Person	$250,
Per Covered Family	$500, NOTE: Must be individually satisfied by 2 Separate Covered Persons
Emergency Room Copayment (waived if admitted within 24 hours)	$50
Coinsurance	20% **except as stated below**
Exception: For charges for Non-Biologically Based Mental Illnesses and Substance Abuse treatment	25%
Coinsured Charge Limit	$10,000

MAXIMUM LIFETIME BENEFITS	$5,000,000, **except** as otherwise stated

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES

THE SERVICES, SUPPLIES AND BENEFITS COVERED UNDER THE CONTRACT ARE SUBJECT TO THE PAYMENT OF THE APPLICABLE COPAYMENTS, DEDUCTIBLE AND COINSURANCE.

SERVICES	IN-NETWORK	OUT-OF-NETWORK
Hospital		
Inpatient (unlimited days)	$75 Copayment / day; maximum / admission $375; maximum / cal. year $750	Deductible/Coinsurance
Outpatient Visit	$5 Copayment / visit	Deductible/Coinsurance
Practitioner services provided at a Hospital		
Inpatient Visit	$0 Copayment / visit	Deductible/Coinsurance
Outpatient Visit	$5 Copayment / visit; waived if another Copayment applies	Deductible/Coinsurance
Emergency Room	$50 Copayment / visit; credited toward Inpatient Copayment if admission occurs within 24 hours	$50 Copayment; waived if admission occurs within 24 hours; Deductible/Coinsurance
Maternity	$25 Copayment for initial visit only; $0 Copayment thereafter	Deductible/Coinsurance
Practitioner Services	$5 Copayment / visit	Deductible/Coinsurance
Preventive Care; NOTE: Out-of-Network benefits LIMITED; Refer to the Covered Charges section	$5 Copayment / visit	See the Covered Charges Section
Surgery		
Inpatient	$0 Copayment	Deductible/Coinsurance
Outpatient Visit	$5 Copayment	Deductible/Coinsurance
Pre-Admission Testing	$5 Copayment	Deductible/Coinsurance
Second Surgical Opinion	$5 Copayment	Deductible/Coinsurance

SERVICES	IN-NETWORK	OUT-OF-NETWORK
Specialist Services	$5 Copayment	Deductible/Coinsurance
Therapy Services NOTE: Limited Benefits. Refer to the Covered Services and Supplies and Covered Charges sections	$5 Copayment	Deductible/Coinsurance
Diagnostic Services Inpatient Outpatient Visit	 $0 Copayment $5 Copayment	 Deductible/Coinsurance Deductible/Coinsurance
Rehabilitation Services NOTE: Out-of-Network benefits LIMITED. Refer to the Covered Charges section	Subject to the Hospital Inpatient Copayment; waived if admission immediately preceded by inpatient hospitalization	Deductible/Coinsurance
Skilled Nursing Center NOTE: Out-of-Network benefits LIMITED. Refer to the Covered Charges section	$0 Copayment	Deductible/Coinsurance
Non-Biologically Based Mental Illness and Substance Abuse	**Inpatient:** $75 Copayment/day; maximum/admission $375; maximum/Calendar Year $750; Maximum 30 days/Calendar Year	Deductible/Coinsurance **Inpatient:** Maximum 30 days/Calendar Year
	Outpatient: $5 Copayment/ visit; Maximum 20 visits/Calendar Year. Refer to the Covered Services and Supplies section for an explanation of the rules for exchange	**Outpatient:** Maximum 20 visits/Calendar Year. Refer to the Covered Charges with Special Limitations Applicable to Out-of-Network Benefits section for an explanation of the rules for exchange
Biologically-Based Mental Illness and Alcohol Abuse Outpatient	$5 Copayment/visit	Deductible/Coinsurance
Inpatient	$75 Copayment/day; maximum/admission $375; maximum/Calendar Year $750	Deductible/Coinsurance

SERVICES	IN-NETWORK	OUT-OF-NETWORK
Therapeutic Manipulation: Limited Benefit. Refer to the Covered Services and Supplies and Covered Charges sections	$5 Copayment / visit	Deductible/Coinsurance
Prescription Drugs	$5 Copayment per prescription;	Deductible/Coinsurance
Home Health Care	Covered; $0 Copayment	Deductible/Coinsurance; Subject to Pre-Approval
Hospice Care	Covered; $0 Copayment	Deductible/Coinsurance; Subject to Pre-Approval
Podiatric Care	$5 Copayment / visit	Deductible/Coinsurance

NOTE: NO IN-NETWORK SERVICES OR SUPPLIES WILL BE PROVIDED IF A MEMBER FAILS TO OBTAIN PRE-AUTHORIZATION OF CARE THROUGH HIS OR HER PRIMARY CARE PHYSICIAN. READ THE MEMBER PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES. OUT-OF-NETWORK BENEFITS MAY BE PROVIDED, SUBJECT TO THE TERMS AND CONDITIONS OF THE CONTRACT CONCERNING OUT-OF-NETWORK BENEFITS. PLEASE READ THE UTILIZATION REVIEW FEATURES SECTION CAREFULLY. THE UTILIZATION REVIEW FEATURES SECTION CONTAINS A PENALTY FOR NON-COMPLIANCE.

REFER TO THE SECTION OF THE CONTRACT CALLED "NON-COVERED SERVICES AND SUPPLIES AND NON-COVERED CHARGES" FOR A LIST OF THE SERVICES AND SUPPLIES AND CHARGES FOR WHICH A MEMBER IS NOT ELIGIBLE.

FOR ANY SPECIFIC IN-NETWORK SERVICES AND SUPPLIES WHICH ARE SUBJECT TO LIMITATION, ANY SUCH IN-NETWORK SERVICES OR SUPPLIES THE MEMBER RECEIVES AS A IN-NETWORK SERVICE OR SUPPLY WILL REDUCE THE CORRESPONDING OUT-OF-NETWORK BENEFIT FOR THAT SERVICE OR SUPPLY. SIMILARLY, FOR ANY SPECIFIC OUT-OF-NETWORK BENEFITS WHICH ARE SUBJECT TO LIMITATION, ANY SUCH BENEFITS THE MEMBER RECEIVES AS OUT-OF-NETWORK COVERED CHARGES WILL REDUCE THE CORRESPONDING IN-NETWORK SERVICES AND SUPPLIES AVAILABLE FOR THAT SERVICE OR SUPPLY. THE IN-NETWORK SERVICES AND SUPPLIES SECTION AND THE OUT-OF-NETWORK COVERED CHARGES SECTION CLEARLY IDENTIFY WHICH SERVICES AND SUPPLIES AND COVERED CHARGES ARE AFFECTED BY THIS REDUCTION RULE.

Daily Room and Board Limits ***Applicable to Out-of-Network Benefits***

During a Period of Hospital Confinement
For semi-private room and board accommodations, We will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, We will cover charges up to the Hospital's average semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Member is being isolated in a private room because the Member has a communicable Illness, We will cover charges up to the Hospital's actual private room charge.

For Special Care Units, We will cover charges up to the Hospital's actual daily room and board charge for the Special Care Unit.

During a Confinement in an Extended Care Center or Rehabilitation Center
We will cover the lesser of:

a) the center's actual daily room and board charge; or
b) 50% of the covered daily room and board charge made by the hospital during the Member's preceding Hospital confinement, for semi-private accommodations.

DEFINITIONS

The words shown below have specific meanings when used in the Contract. Please read these definitions carefully. Throughout the Contract, these defined terms appear with their initial letters capitalized. They will help Members understand what services and supplies and benefits are provided.

ALCOHOL ABUSE. Abuse of or addiction to alcohol. Alcohol Abuse does not include abuse of or addiction to a substance. Please see the definition of Substance Abuse.

AMBULANCE. A certified transportation vehicle for transporting Ill or Injured people that contains all life-saving equipment and staff as required by applicable state and local law.

AMBULATORY SURGICAL CENTER. A Facility mainly engaged in performing Outpatient Surgery. It must:

a) be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
b) have operating and recovery rooms;
c) be staffed and equipped to give emergency care; and
d) have written back-up arrangements with a local Hospital for emergency care.

It must carry out its stated purpose under all relevant state and local laws and be either:

a) accredited for its stated purpose by either the Joint Commission or the Accreditation for ambulatory care; or
b) approved for its stated purpose by Medicare.

A Facility is not an Ambulatory Surgical Center, for the purpose of the Contract, if it is part of a Hospital.

ANNIVERSARY DATE. The date which is one year from the Effective Date of the Contract and each succeeding yearly date thereafter.

AFFILIATED COMPANY. A corporation or other business entity affiliated with the Contractholder through common ownership of stock or assets.

BIOLOGICALLY-BASED MENTAL ILLNESS. A mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to: schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder and pervasive developmental disorder or autism.

BIRTHING CENTER. A Facility which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
b) be staffed and equipped to give emergency care; and
c) have written back-up arrangements with a local Hospital for emergency care.

It must:

a) carry out its stated purpose under all relevant state and local laws; or

b) be approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
c) be approved for its stated purpose by Medicare.

A Facility is not a Birthing Center, for the purpose of the Contract, if it is part of a Hospital.

BOARD. The Board of Directors of the New Jersey Small Employer Health Program.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

CASE MANAGER. An entity designated by Us to manage, assess, coordinate, direct and authorize the appropriate level of health care treatment.

CASH DEDUCTIBLE or DEDUCTIBLE. The amount of Covered Charges that a Member must pay before the Contract pays any benefits for such charges. Cash Deductible does not include Coinsurance, Copayments, and Non-Covered Services and Supplies and Non-Covered Charges. See the **Cash Deductible** section of the Contract for details.

CHURCH PLAN. Has the same meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974"

COINSURANCE. The percentage of Covered Services or Supplies or the percentage of Covered Charges, as applicable, that must be paid by a Member. Coinsurance does **not** include the Cash Deductible, Copayments, or Non-Covered Services and Supplies and Non-Covered Charges.

CONTRACT. The Contract, including the application and any riders, amendments or endorsements, between the Contractholder and Us.

CONTRACTHOLDER. Employer or organization which purchased the Contract.

COPAYMENT. A specified dollar amount which Member must pay for certain Covered Services or Supplies or Covered Charges. ***NOTE:*** *The Emergency Room Copayment, if applicable, must be paid in addition to any other Copayments, Cash Deductible, and Coinsurance.*

COSMETIC SURGERY OR PROCEDURE. Any surgery or procedure which involves physical appearance, but which does not correct or materially improve a physiological function and is not Medically Necessary and Appropriate.

COVERED CHARGES. Reasonable and Customary charges for the types of services and supplies described in the **Covered Charges** and **Covered Charges with Special Limitations** section of the Contract, as applicable to Out-of-Network benefits. The services and supplies must be:
a) furnished or ordered by a health care Provider; and
b) Medically Necessary and Appropriate to diagnose or treat an Illness or Injury.

A Covered Charge is incurred on the date the service or supply is furnished. Subject to all of the terms of the Contract, We pay benefits for Covered Charges incurred by a Member while he or she is covered by the Contract. Read the entire Contract to find out what We limit or exclude.